MEDICAL & DENTAL HISTORY

111 East Union Avenue, Bound Brook, NJ 08805   732-356-1830

email to: crystal.duprat@gmail.com

Tell us about your child

Today's Date: ______________________________

Child's Name: ______________________________

Birthdate: _____/_____/_____   Child's Age: ______

Preferred Name: ______________ ☐Male ☐Female

Child's Home #: ______________________________

Child's Home Address:

____

____

Who is accompanying the child today?

Name: ________________ Relation: ____________

Do you have legal custody of this child? ☐ Yes ☐ No

Is the child adopted? ☐ Yes ☐ No

Is the child in a foster home? ☐ Yes ☐ No

Whom may we thank for referring you? ______________

____

Other siblings seen by us: ______________________

Previous/Present Dentist: ______________________

Last Visit Date: ______________________________

Parental Information

☐ **Mother** ☐ Step Mother ☐ Guardian

Name: ______________________________

Birthdate: ____/____/____ Home # ______________

Work # ______________ Cell # ______________

SS#: ____________________________

Occupation: ______________________________

E-Mail: ______________________________

☐ **Father** ☐ Step Father ☐ Guardian

Name: ______________________________

Birthdate: ____/____/____ Home # ______________

Work # ______________ Cell # ______________

SS#: ____________________________

Occupation: ______________________________

E-Mail: ______________________________

Parent's Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partnered ☐ Separated

Primary Dental Insurance

Policy Owner's Name: ______________________

Relationship to Patient: ______________________

Policy Owner's Birthdate: ____/____/____

Policy Owner's SS#: ______________________

Insurance Co. Name: ______________________

Insurance Policy ID #: ______________________

Policy Owner's Employer: ______________________

Insurance Co. Address: ______________________

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Insurance Co. Phone #: ______________________

Insurance Co. Group #: ______________________

Secondary Dental Insurance

Policy Owner's Name: ______________________

Relationship to Patient: ______________________

Policy Owner's Birthdate: ____/____/____

Policy Owner's SS#: ______________________

Insurance Co. Name: ______________________

Insurance Policy ID #: ______________________

Policy Owner's Employer: ______________________

Insurance Co. Address: ______________________

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Insurance Co. Phone #: ______________________

Insurance Co. Group #: ______________________

I certify that my child is covered by the above Insurance Co. and I assign directly to Comprehensive Pediatric Dentistry all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefit. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

____

Signature of parent or guardian   Date

Why did you bring the child to the dentist today?

____

____

Has your child ever had a serious / difficult problem associated with previous dental work? ☐ Y ☐ N

If yes, please explain: ____________________________

____

Is the child's water fluoridated? ☐ Y ☐ N

Is the child taking fluoridated supplements? ☐ Y ☐ N

Has the child ever had any pain / tenderness in his / her jaw joint (TMJ / TMD)? ☐ Y ☐ N

Does the child brush his / her teeth daily? ☐ Y ☐ N

Floss his / her teeth daily? ☐ Y ☐ N

Has the child ever taken Fosamax, Actonel, Boniva or any other bisphosphonate? ☐ Y ☐ N

Child's Physician: ____________________________

Phone # ________________ Date of last visit: ________

Please describe the child's current physical health:

☐ Good ☐ Fair ☐ Poor

Please list all medications the child is currently taking:

____

____

Aside from items listed below, list all medications/things the child is allergic to:

____

____

Latex ☐ Y ☐ N Metals/ Nickel ☐ Y ☐ N

Plastic ☐ Y ☐ N

Has the child ever had any of the following medical problems?

☐ Y ☐ N Abnormal Bleeding	☐ Y ☐ N Handicaps/Disabilities
☐ Y ☐ N ADD / ADHD	☐ Y ☐ N Hearing/Vision Loss
☐ Y ☐ N Anemia	☐ Y ☐ N Heart Murmur
☐ Y ☐ N Any Hospital Stays	☐ Y ☐ N Hemophilia
☐ Y ☐ N Any Operations	☐ Y ☐ N Hepatitis
☐ Y ☐ N ArtificialBones/Joints/Valves	☐ Y ☐ N Hives
☐ Y ☐ N Asthma	☐ Y ☐ N HIV+ / AIDS
☐ Y ☐ N Autism/Asperger's/PDD	☐ Y ☐ N Kidney/ Liver Problems
☐ Y ☐ N Cancer	☐ Y ☐ N Measles
☐ Y ☐ N Chicken Pox	☐ Y ☐ N Mononucleosis
☐ Y ☐ N Congenital Heart Defect	☐ Y ☐ N Rheumatic/ Scarlet Fever
☐ Y ☐ N Convulsions	☐ Y ☐ N Sensory Issues
☐ Y ☐ N Diabetes	☐ Y ☐ N Sickle Cell Disease/Traits
☐ Y ☐ N Epilepsy	☐ Y ☐ N Skin Rash
☐ Y ☐ N Exposed to HIV, but Neg.	☐ Y ☐ N Tuberculosis (TB)

Are the child's immunizations current? ☐ Y ☐ N

Anything you would like to discuss with the Doctor in private? ☐ Y ☐ N

Please discuss any serious medical problem that the child has had: ____________________________

____

____

Does / did the child have any of the following habits?

☐ Y ☐ N Lip Sucking / Biting ☐ Y ☐ N Nursing Bottle Habits

☐ Y ☐ N Nail Biting ☐ Y ☐ N Thumb/Finger Sucking

Was the child breast fed? ☐ Y ☐ N

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

____

Signature of parent or guardian Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may Refuse to Sign This Acknowledgement

I, ______________________________, have received a copy of this office's Notice of Privacy Practices.

____

Signature of parent or guardian Date

____ Individual refused to sign